SECRETARY OF LABOR,
Washington, DC, November 18, 1999.

Hon. DON NICKLES,
U.S. Senate,
Washington, DC.

DEAR SENATOR NICKLES: This is a follow-up to the meeting of our respective staffs yesterday. While the Department of Labor recognizes that employers have the flexibility to determine the number and length of breaks they offer to their employees, the Wage and Hour Division has taken the position that if an employer offers a break of less than 20 minutes in duration, the time the employee spends on that break typically is compensable hours worked under the Fair Labor Standards Act.

Most of the Wage and Hour Opinion Letters that address this issue involve authorized breaks. However, on several occasions, the Wage and Hour Administrator has stated that short unauthorized breaks may also count as hours worked. Wage and Hour has taken the position that if an employee exceeds the time allotted for an authorized break, an employer may take a disciplinary action against the employee, or the employer may eliminate the option for rest periods/breaks.

I am committing the Wage and Hour Division and the Solicitor's Office to carefully review our policy with respect to the compensability of unauthorized break time under the FLSA. Our review will specifically include those instances in which employees exceed the time allowed for a rest break. We will also consider what outcome is in the best interests of the employee if the employee exceeds the allotted time for a rest period/break, including the option of deductions of compensation for the time taken in excess of the allotted break time.

As part of our review, we will consider the statutory text, relevant legislative history and regulatory material, case law, previous Wage and Hour Opinion Letters, changing technology and any information that your office or a member of the public may provide. We will complete our review of this matter by February 1, 2000, and transmit our conclusions and supporting rationale in writing to the Chairman and Ranking Members of the relevant committees in the House and the Senate.

It is important that all officials of the Wage and Hour Division interpret and apply the law in a uniform manner, and so advise the public. I will instruct the Wage and Hour Division to assure that the resolution of any cases in which unauthorized break time are at issue is consistent with the outcome we reach in our overall review.

I very much appreciate your interest in these important questions.

Sincerely,

ALEXIS M. HERMAN.

COMPENSATING CERTAIN DEPARTMENT OF ENERGY WORKERS

Mr. THOMPSON. Mr. President, yesterday, my colleague from New Mexico, Senator BINGAMAN, and I introduced legislation that is, frankly, long overdue.

For more than 2 years, I have been concerned that the Department of Energy was not taking seriously the complaints of a number of workers in Oak Ridge, Tennessee who are ill and who believe that their illnesses are linked to their employment at the DOE site in Oak Ridge. In November of 1997, two years ago, I wrote to the then-Surgeon General, Dr. David Satcher, to request that the Centers for Disease Control, CDC, come to Oak Ridge to try to determine whether a pattern of unexplained illnesses was present and, if so, if its cause could be determined. The CDC study, like others before it, looked at a narrow sample of individuals and did not produce conclusive results.

Since then, I have been working to get the Department of Energy to acknowledge that there is a problem, that certain of its current and former workers are ill, and that they should work with us to address the situation. This legislation—which we developed in conjunction with the Department—is an important step in that direction.

It says, for the first time, that if mistakes were made, and if harm was done to workers who helped this country win the Cold War, we need to act now to remedy those mistakes. It represents a recognition on the part of the government that if people have illnesses that are linked to their employment at a Department of Energy facility, they deserve compensation. That is progress, and I am proud to be a part of it.

Our bill has three parts. The first section, the Energy Employees' Beryllium Compensation Act, would provide compensation to current and former workers who have contracted chronic beryllium disease or beryllium sensitivity while performing duties uniquely related to the Department of Energy's nuclear weapons production program. There are approximately 90 Oak Ridge workers who have been diagnosed with either chronic beryllium disease or beryllium sensitivity to date, and a total of 2,200 Oak Ridge workers who were potentially exposed.

The second section, the Energy Employees' Pilot Project Act, would establish a special pilot program for a specific group of 55 Oak Ridge workers who are currently the subject of an investigation by a panel of physicians specializing in health conditions related to occupational exposure to radiation and hazardous materials. This section authorizes the Secretary of Energy to award $100,000 each to those Oak Ridge workers whose illnesses are determined to likely be linked to their employment at the Oak Ridge site.

Finally, our bill creates the Paducah Employees' Exposure Compensation Fund, which would compensate those current and former workers at the Paducah, KY gaseous diffusion plant who were exposed to plutonium and other radioactive materials without their knowledge, and who develop one of a specified list of conditions linked to radiation exposure. I want to note that there are workers at the K–25 gaseous diffusion plant in Oak Ridge who were exposed to the same contaminants as those in Paducah, and workers in Portsmouth, Ohio who were similarly affected as well. It is my hope that these two groups of workers would be added to this section of the legislation, upon the conclusion of the Department of Energy's investigation into what happened at these two sites, if the facts so warrant. Their absence at this time should in no way indicate that either the sponsors of this bill or the Department of Energy believe that they were not similarly affected. I strongly believe that workers at all of the DOE sites must be treated equally in this process, and I am committed to doing all I can to ensure that that is the case.

Let me just remind my colleagues who it is we are talking about. We are talking about workers who participated in the Manhattan Project, men and women who helped to ensure the superiority of America's nuclear arsenal, and who directly contributed to our nation's victory in the Cold War. We owe them a debt of gratitude. And if we put them in harm's way without their knowledge, it's time for us to make that right. This bill is a step in that direction. I look forward to its consideration by the Senate.

PAIN RELIEF PROMOTION ACT

Mr. NICKLES. Mr. President, on June 23, 1999, Senator LIEBERMAN and I introduced S. 1272, the Pain Relief Promotion Act, which addresses two specific concerns. First, it provides federal support for training and research in palliative care. Second, it clarifies federal law on the legitimate use of controlled substances. On October 27, 1999 the House passed its companion measure H.R. 2260 by the resounding bipartisan vote of 271 to 156. It is my hope that the Senate will soon have the opportunity to debate and vote on this important legislation.

In anticipation of that debate, and in light of inaccurate characterizations of the second aspect of our bipartisan legislation, I believe it is important for me to ensure that the Record reflects precisely how this bill will—and will not—affect current federal law with regard to Drug Enforcement Administration (DEA) oversight of the use of federally controlled substances.

To understand the effect the Pain Relief Promotion Act will have on pain control, we must begin with what the law is now. The Controlled Substances Act, CSA, of 1970 charged the DEA with the responsibility of overseeing narcotics and dangerous drugs—including powerful prescription drugs which have a legitimate medical use but can also be misused to harm or kill. In asserting its authority over these drugs, Congress declared in the preamble of the Controlled Substances Act of 1970 that ''Federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic'' (21 U.S.C. 801 (6)).

In 1984, Congress amended the CSA due in part to a specific concern regarding the misuse of prescription drugs in lethal overdoses. The then Democratic-controlled House and a Republican Senate further strengthened the Act, empowering the DEA to revoke a physician's federal prescribing

license if he or she uses it to endanger ''health and safety'' regardless of whether state law has been violated (21 U.S.C. 824, referencing 21 U.S.C. 823). The chairman of the Health subcommittee in the House agreed: ''Drugs legally manufactured for use in medicine are responsible for a substantial majority of drug-related deaths and injuries'' (Rep. WAXMAN, Hearing of July 31, 1984, Hearing Record No. 98–168, p. 365). Congress' view was that while the states are the first line of defense against misuse of prescription drugs, the Federal Government must have its own objective standard as to what constitutes such misuse—and it must have the authority to enforce that standard when a state cannot or will not do so. Congress' 1970 and 1984 decisions have been upheld time and time again by federal courts.

It is clear that federal law is intended to prevent use of these drugs for lethal overdoses, and contains no exception for deliberate overdoses approved by a physician. Nowhere in the Controlled Substances Act has death or assisting death ever been considered a ''legitimate medical purpose'' for use of these drugs. In the past, physicians who were involved in the use of these drugs for suicide or other lethal overdoses have lost their federal authority to prescribe controlled substances on the grounds that they had endangered ''health and safety.''

In 1997, Congress passed the Assisted Suicide Funding Restriction Act of 1997 without a dissenting vote in the Senate and by an overwhelming margin of 398–16 in the House. President Clinton stated in signing the bill that ''it will allow the Federal Government to speak with a clear voice in opposing these practices.'' He further warned that ''to endorse assisted suicide would set us on a disturbing and perhaps dangerous path.'' I would add only that authorizing a federal agency to endorse the use of controlled substances for assisted suicide would similarly ''set us on a disturbing and perhaps dangerous path.''

In November 1994, the State of Oregon adopted by referendum the so-called ''Death with Dignity Act,'' allowing physicians to prescribe medication for the purpose of assisting patients' suicides. The week of that vote, Professor George Annas of Boston University pointed out the inconsistency between the Oregon referendum and the Controlled Substances Act in an article in the New England Journal of Medicine. He questioned whether such a state law was compatible with existing federal laws governing federally controlled drugs, ''since the drafters of the federal statute certainly did not have this purpose [assisting suicides] in mind.''

However, on June 5, 1998, overturning a previous determination by her own DEA Administrator, the Attorney General issued a letter carving out an exception for Oregon so it can use federally-controlled substances for assisted suicide. She claimed that Congress did not ''intend to override a state determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice.'' The Pain Relief Promotion Act will respond to the Attorney General's challenge, by clarifying that the intentional misuse of these drugs to cause patients' deaths is not authorized by Congress in any state, nor has it ever been.

On October 27, 1997, Oregon's ''Death with Dignity Act'' became effective. In the first year at least 15 patients have committed suicide with doctor's assistance under the new Oregon law. We really do not know the total number, because all reporting of cases is left completely in the hands of the doctors themselves, and the Oregon Health Division admits it has no idea how many unreported cases there are. But regarding those 15 reported cases we know one thing: Every one of those patient's deaths was caused by a federally controlled substance, prescribed with a federal DEA registration number, using federal authority. Today, without any decision to this effect by Congress or the President, the federal government is actively involved in assisting suicides in Oregon.

To hear some of the critics of this bill you might think that the Pain Relief Promotion Act creates a new authority on the part of the DEA to revoke doctors' registrations if they use controlled substances to assist suicide. On the contrary that authority has existed for 29 years and it exists now. Attorney General Janet Reno was very clear on this matter in her letter of June 5, 1998: ''Adverse action under the CSA may well be warranted . . . where a physician assists in a suicide in a state that has not authorized the practice under any conditions, or where a physician fails to comply with state procedures in doing so.''

What does this mean for current law and practice? First, the DEA has full authority to revoke a DEA registration for assisting suicide in any of the 49 states where assisting suicide is not authorized by state law. While critics of the Pain Relief Promotion Act have said that empowering the DEA to investigate physicians in such cases will have a ''chilling effect'' on the treatment of pain, the fact is that such authority already exists in 49 states.

What about the one State, Oregon, where the Attorney General said the DEA will not take adverse actions against physicians for assisting suicide in compliance with the Oregon law? Even in Oregon many cases of assisting suicide remain illegal under state law. The state law authorizes assisting the suicide of those who are terminally ill, but not others. Under the Attorney General's determination, then, the DEA can continue to review cases of assisting suicide to make sure they do not involve those who are not terminally ill, and it can scrutinize whether a given use of pain medication was really intended to assist suicide. All aspects of the Oregon guidelines for legally valid assisted suicide are also subject to DEA investigation, since the Attorney General has only authorized physicians to use federally controlled drugs for assisted suicides when they fully comply with those state guidelines.

Thus, as interpreted by the Attorney General, a registration to prescribe federally controlled substances can be revoked under the current Controlled Substances Act if these substances are used to assist suicide in any state in the Nation, with the exception of certain cases of assisted suicide that Oregon has legalized for the terminally ill. If DEA scrutiny of doctors' prescribing practices were going to ''chill'' the practice of pain control, that would already be occurring under current law.

How does the Pain Relief Promotion Act impact this situation? It establishes that, for the first time in federal law, the use of controlled substances for the relief of pain and discomfort is a ''legitimate medical purpose,'' even if the large doses used in treating pain may unintentionally hasten death. Intentionally causing death or assisting in causing death remains forbidden. Thus this bill does not increase the DEA's regulatory authority at all. On the contrary, its only effect in 49 states (and even in Oregon, in cases involving those who are not terminally ill) is to provide new legal protection for physicians who prescribe controlled substances to control pain.

In Oregon, this bill eliminates the Attorney General's artificial exception designed to accommodate assisted suicides that are no longer penalized under Oregon law. The DEA can meet its responsibility here simply by looking at the reports required by Oregon law, in which doctors must identify the drugs used to assist suicide. Those records will make it clear whether federally controlled drugs were used; and since the physician is clearly reporting that his or her own intent was to help cause death, there will be no question of murky intentions or ambiguity. Thus this bill will not lead to any increase in the DEA trying to ''second guess'' or infer physicians' intentions, even in Oregon.*****-*****- -Name: -Payroll No. -Folios: J1S/13-J1S/14 -Date: -Subformat:

What of any unreported cases in which physicians assist the suicides of terminally ill patients? Those assisted suicides are already a crime under Oregon law, and thus already subject to adverse action by the DEA as well under the Attorney General's interpretation. Only if a physician officially reports the case to the Oregon Health Division is he or she exempted from state criminal penalties. So those cases are already covered by the same DEA authority that currently applies to assisted suicides in the other 49 states.

Let me take this situation step by step.

First, removing the Oregon exception to the existing nationwide policy cannot increase any ''chilling effect'' on

pain relief outside of Oregon, because the bill does not increase one iota the authority of the DEA to investigate the misuse of controlled substances to assist suicide outside of Oregon. In fact, in those states its only effect is to provide a more explicit ''safe harbor'' for the practice of pain control, which is a significant advance and improvement for doctors and terminally ill patients. This is also true of assisted suicide cases within Oregon that do not comply with the state's reporting requirements or other guidelines. In all these cases, the Pain Relief Promotion Act gives the DEA no new mandate to investigate cases of assisted suicide more directly. Rather, it is expected to follow its longstanding practice of generally deferring to state authorities and allowing them to take the lead in investigating possible wrongdoing.

Second, no new questioning of physicians' intentions is warranted to address the cases of assisted suicide that are now permitted under Oregon law. To be free of criminal penalties under state law in Oregon, a doctor who assists a suicide must submit a report to Oregon authorities that includes information on the drugs prescribed to assist the suicide. The Drug Enforcement Administration, DEA, can obtain those reports from the Oregon authorities. It already has the authority to subpoena them, if necessary; again, our legislation has no impact on this.

Thus, even in Oregon, this bill will not result in any increase in DEA oversight or investigations of doctors based on their prescribing patterns or the dosages they use for particular patients. This is clearly stated in the House Judiciary Committee report on this bill, H. Rep. 106–378 Pt. 1, pp. 12–13.

It follows that if this bill is enacted, any doctors in Oregon who prescribe controlled substances for pain relief need not fear any increase in DEA scrutiny of their practices, and therefore should not in any way be deterred from prescribing adequate pain relief.

This bill cannot have a ''chilling effect'' on pain control, but will have the opposite effect. For the first time, it will place in the Controlled Substances Act, as the American Society of Anesthesiologists notes, ''recognition that alleviating pain in the usual course of professional practice is a legitimate medical purpose for dispensing a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death.'' The American Medical Association says this bill, ''provides a new and important statutory protection for physicians prescribing controlled substances for pain, particularly for patients at the end of life.'' As the American Academy of Pain Management observes, this will protect the ability of ''prescribers to relieve pain without fear of regulatory discipline.''

Those who are concerned about the possibility of a negative impact on pain relief if we pass this bill need to answer this question: do they believe that now the Drug Enforcement Administration is having a chilling effect on pain relief because federally controlled substances cannot be used to assist suicide in 49 states and even, in many cases, in Oregon?

If the answer is ''no,'' then there is no basis to be concerned about this bill—for this bill will not increase investigations or oversight into the dosages of drugs used for pain relief, and in fact instructs the DEA to be even more sensitive to physicians' need to prescribe large doses of these drugs for pain control.

If the answer is ''yes,'' then there is a great need for this bill—because for the first time it adds specific protections for doctors who prescribe controlled substances for pain control—resulting in a decrease in any ''chilling effect'' that may exist under current law.

Let me quote from the American Medical Association:

> The bill would not expand existing criminal penalties in the CSA for persons whose unauthorized use of a controlled substance leads to someone's death. . . . The bill would not expand the DEA's authority concerning jurisdiction, investigations or enforcement regarding the CSA. In fact, the inclusion of a recognition of the ''double effect'' in the CSA provides physicians in all jurisdictions an additional statutory protection in cases of alleged [physician-assisted suicide]. The bill has the potential, through its educational provisions, of sensitizing law enforcement personnel to the multiple issues of end-of-life care and prescribing.

It is noteworthy that although the Justice Department expressed concern about the portion of the bill that would prevent the use of federally controlled substances to assist suicide in Oregon, it agrees that the bill would aid, and not hinder, pain relief. In a letter dated October 19,1999, the Justice Department wrote that the bill ''would eliminate any ambiguity about the legality of using controlled substances to alleviate the pain and suffering of the terminally ill by reducing any perceived threat of administrative and criminal sanctions in this context. The Department accordingly supports those portions of [the bill] addressing palliative care.''

This bill makes it easier, not harder, to use controlled substances to relieve pain. That is why so many major medical organizations, including the National Hospice Organization, the American Academy of Pain Management and the American Society of Anesthesiologists, as well as the AMA, strongly support its enactment.

Some may wish to abolish the Controlled Substances Act altogether. They may think that the federal government's longstanding insistence on monitoring the distribution of these powerful drugs is an unwarranted intrusion into medical practice. I disagree with that stand, but at least it can be understood as a consistent position. What is untenable is the claim that this particular bill, which clearly improves the law's sensitivity to medical judgments on pain control, somehow mysteriously worsens that situation. Once we understand what the current law is and what this bill does, that claim simply does not make sense.

In short, the Pain Relief Promotion Act will foster pain control. It will improve existing law by adding significant new legal protections for physicians and pharmacists who prescribe and dispense controlled substances for pain control. It will reduce, and in no way increase, any possible ''chilling effect'' that could deter adequate pain control. And by clarifying federal law so the federal government will not facilitate the medical institutionalization of assisted suicide in any state, this legislation may help discourage doctors from simply suggesting assisted suicide instead of working to address their patients' real problems of uncontrolled pain. As protectors of public health and safety we should be encouraging doctors to kill the pain, not the patient.

Mr. President, I ask unanimous consent that the following two editorials be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, Nov. 4, 1999]

DON'T KILL THE PAIN-RELIEF BILL

(By Wesley J. Smith)

Last week, by a vote of 271–156, the House approved the Pain Relief Promotion Act, designed to promote effective medical treatment of pain while deterring the misuse of narcotics and other controlled substances for assisted suicide. The bill's passage prompted an outpouring of hyperbole and misinformation from opponents. Here are the facts about the act:

It would not outlaw assisted suicide, Critics accuse Congress of ''overturning'' Oregon's assisted-suicide referendum. Would that it did. In fact, the act would outlaw only the intentional use of controlled substances to cause death. Lethal substances not controlled by federal drug regulations could still be prescribed legally on Oregon for use in assisted suicide.

It would not interfere with states' rights. Under the Controlled Substances Act the federal government, not the states, has the authority to determine what is and is not a proper medical use of the drugs specified in the act. Thus, as an editorial in the (Portland) Oregonian noted, it is the Oregon law that ''barges into an area of long-standing federal jurisdiction.'' Thus passage of the act would return national uniformity to the enforcement of federal drug laws.

It merely reaffirms existing federal law. Because the act declares that assisted suicide is not a ''legitimate medical purpose'' under the Controlled Substances Act, critics have wrongly accused supporters of granting new authority to the Drug Enforcement Agency to punish doctors. In fact, DEA has had that authority for nearly 30 years. Since 1980 it has brought more than 250 enforcement actions for violating the federal legal standard of ''legitimate medical purpose.''

The medical community overwhelmingly favors it. Proponents of the bill include the American Medical Association, the National Hospice Organization, the Hospice Association of America, the American Academy of

Pain Management, the American Society of Anesthesiologists and the American College of Osteopathic Family Physicians. (True, support isn't unanimous. Dissent within the medical community has been led by the Rhode Island Medical Association.)

It has broad bipartisan support. Seventy-one House Democrats voted for the bill, and its Senate sponsors include Joe Lieberman (D., Conn.), Chris Dodd (D., Conn.) and Evan Bayh (D., Ind.).

It would enhance pain control. If the act becomes law, pain control will for the first time be specifically identified in federal law as a proper use of controlled substances—even if the use of pain-controlling drugs has the unintended side effect of causing death. That is a much-needed legal reform, because many doctors fail to treat pain aggressively because they fear the government's second-guessing. Several states have recently passed similar laws, leading to dramatic increases in the use of morphine and other palliative medications.

The Pain Relief Promotion Act looks likely to pass the Senate. If President Clinton truly feels our pain, he will sign it the moment it hits his desk.

[From the Oregonian, July 1, 1999]

KILL THE PAIN, NOT THE PATIENTS

CONGRESS SHOULD ALLOW DOCTORS TO USE CONTROLLED DRUGS FOR AGGRESSIVE PAIN TREATMENT INSTEAD OF SUICIDE

It's no secret to any reader of this space that we oppose Oregon's venture into physician-assisted suicide.

But last year, when the American Medical Association and the National Hospice Organization came out against a bill in Congress giving medical review boards the power to deny or yank the federal drug-prescribing license to physicians who prescribed these drugs to assist in suicides, we took their concerns seriously.

The groups argued that the proposed law could reverse recent advances in end-of-life care. Doctors might become afraid to prescribe drugs to manage pain and depression—things that, when uncontrolled, can lead the terminally ill to consider killing themselves in the first place. We thought then that the problem could be worked out and that it was possible to keep doctors from using federally controlled substances to kill their patients without also preventing them from relieving their terminally-ill patients' agonies.

This Congress's Pain Relief Promotion Act proves it, and the proposed legislation comes not a moment too soon. A new report by the Center for Ethics in Health Care at Oregon Health Sciences University shows that end-of-life care in Oregon—which fancies itself a leader in this area—is far from all it should be. Too many Oregonians spend the last days of their life in pain.

There's no real need for that—and the Pain Relief Promotion Act of 1999 would go a long way toward addressing these systemic and professional failures here and elsewhere. The proposal would authorize federal health-care agencies to promote an increased understanding of palliative care and to support training programs for health professionals in the best pain management practices. It would also require the Agency for Health Care Policy and Research to develop and share scientific information on proper palliative care.

Further, the Pain Relief Promotion Act would clarify the Controlled Substances Act in two essential ways.

One, it makes clear that alleviating pain and discomfort is an authorized and legitimate medical purpose for the use of controlled substances.

Two, the bill states that nothing in the Controlled Substances Act authorizes the use of these drugs for assisted suicide or euthanasia and that state laws allowing assisted suicide or euthanasia are irrelevant in determining whether a practitioner has violated the Controlled Substances Act.

Technically, of course, the bill does not overturn Oregon's so-called Death with Dignity Act. But it would thwart it, for all practical purposes, because it makes it illegal for Oregon doctors to engage in assisted suicide using their federal drug-prescribing license. Suicide's advocates may think of some other method, but none seems obvious.

Is this a federal intrusion on a state's right to allow physician-assisted suicide or euthanasia?

To hear some recent converts to states' right talk, you might think so. But you could just as easily argue that Oregon's assisted suicide law intrudes on the federal domain. The feds have long had jurisdiction over controlled substances, even as states kept the power to regulate the way physicians prescribe them. At best, it's a gray area.

You'll recall that the Department of Justice declined to assert a federal interest in all of this when it plausibly could have, shortly after Oregon voters approved assisted suicide. It's probably better—and high time—that Congress asserts that interest explicitly.

This act would establish a uniform national standard preventing the use of federally controlled drugs for assisted suicide. That, in itself, should advance the national debate on this subject in a more seemly way than, say, the recent efforts of Dr. Jack Kervorkian.

Beyond that, it's high time that Congress made clear that improved pain relief is a key objective of our nation's health-care institutions and our Controlled Substances Act. The Pain Relief Promotion Act will do all this. No wonder the American Medical Association and the National Hospice Organization are now on board.

PRISON CARD PROGRAM

Mr. ASHCROFT. Mr. President I rise today to talk about an important and highly successful program operated for more than 25 years by the Salvation Army in conjunction with the Bureau of Prisons. This program is called the Prison Card Program. Under the program, greeting cards are donated to the Salvation Army that are then given to inmates at correctional facilities across the country. This program allows inmates to keep in touch with family and friends—not only during the holiday season—but throughout the year. The benefits of this program to the inmates and their loved ones are clear. However, there are also benefits to the community as well. Inmates who maintain strong ties with their families and friends are less likely to return to prison once their sentence is completed.

I want to commend the Salvation Army, the Department of Justice, and the Bureau of Prisons for supporting this program. In particular, I want the Department to know that this program has the support of Congress. I have spoken to Chairman GREGG, who has indicated that he is prepared to work with me and other supporters of the program in the coming months to ensure that this important charitable program is sustained well into the future.

THE CARIBBEAN BASIN INITIATIVE AND THE IMPACT ON TRADE WITH ISRAEL

Mr. JOHNSON. Mr. President. I would like to alert my colleagues to an issue raised by H.R. 434, the African Growth and Opportunity Act and the Caribbean Basin Initiative, regarding trade with Israel under the U.S.-Israel Free Trade Area Agreement. Notwithstanding our free-trade agreement with Israel, the CBI provisions of this legislation would unfairly discriminate against U.S. imports from Israel.

Under that legislation, most U.S. textile products made with Israeli inputs, such as yarn, fabric or thread, would not be eligible for duty free treatment when assembled into apparel in the Caribbean. To illustrate the contrast with current law, today, if a U.S. company uses Israeli yarn in manufacturing fabric, the products made from such fabric would be eligible for CBI benefits. The trade bill creates a unilateral change from the status quo in our trade with Israel and a major barrier to U.S. companies using Israeli-origin inputs.

I would like to submit for the RECORD a letter from the Economic Minister of the Israeli Embassy that was sent to each of the Members of the Senate Finance Committee urging Congress to treat Israeli inputs on par with U.S. inputs in this trade legislation. I ask unanimous consent that letter be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

EMBASSY OF ISRAEL,
Washington, DC, June 15, 1999.

DEAR SENATOR: I am writing to you, as well other members of the Committee on Finance, to ask for your support during the Committee's mark-up of the U.S.-Caribbean Basin Trade Enhancement Act (also known as the ''CBI'' trade parity bill) to ensure that it does not impose an economic barrier against U.S. imports of Israeli-origin inputs, such as yarn, fabric or thread, under the U.S.-Israel Free Trade Area Agreement (''FTAA'').

My Government urges the inclusion of a provision in the CBI legislation that will enable U.S. companies to continue utilizing Israeli-origin inputs in producing American-made products without making such products ineligible for CBI duty-free trade prefrences.

The current CBI trade program provides preferential tariff treatment to apparel made from U.S.-formed components that are finished in a CBI-eligible country. Currently such components may be cut from fabric, or formed from yarn, originating either in the United States or Israel. The legislation before the Committee incorporates a U.S.-only fabric and thread forward rule of origin. The CBI bill recently approved by the House Ways and Means Committee also incorporates a U.S.-only ''yarn forward'' requirement for knit-to-shape products. Either bill in its current form would adversely affect Israeli exports to the United States. Market conditions would all but require U.S. companies to halt imports of Israeli inputs so as not to disqualify their products from the duty-free trade preference to be extended unilaterally to CBI-eligible countries. The loss of sales to the U.S. market would harm